GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 11, 2025

Katelyn Fuerstenberg
StoryPoint Northville
44600 Five Mile Rd
Northville, MI 48168

RE: License #: AH820399661
Investigation #: 2025A0784024
StoryPoint Northville

Dear Katelyn Fuerstenberg:

Attached is the Special Investigation Report for the above-mentioned facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH820399661
Investigation #:	2025A0784024
Complaint Receipt Date:	01/15/2025
Investigation Initiation Date:	01/15/2025
Report Due Date:	03/16/2025
Licensee Name:	44600 Five Mile Rd OpCo LLC
Licensee Address:	4500 Dorr Street Toledo, OH 43615
Licensee Telephone #:	(419) 247-2800
Administrator:	Staci Tripolsky
Authorized Representative:	Katelyn Fuerstenberg
Name of Facility:	StoryPoint Northville
Facility Address:	44600 Five Mile Rd Northville, MI 48168
Facility Telephone #:	(248) 697-2900
Original Issuance Date:	08/12/2020
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	103
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Lack of adequate care for Resident A.	Yes
Improper medication administration.	No
Additional Findings	Yes

III. METHODOLOGY

01/15/2025	Special Investigation Intake 2025A0784024
01/15/2025	Special Investigation Initiated - Telephone Attempted contact with complainant
01/15/2025	Contact - Document Sent Email sent to complainant with request for additional information
01/15/2025	Contact - Document Received Email received from complainant with requested information
01/15/2025	Contact - Telephone call made Interview with complainant
01/16/2025	Inspection Completed On-site
01/16/2025	Contact - Telephone call made Attempted with staff 5
01/16/2025	Contact - Telephone call made Attempted with staff 1
02/28/2025	Contact - Telephone call made Attempted with staff 5
02/28/2025	Contact - Telephone call made Attempted with staff 1
03/03/2025	Contact - Document Received Interview with staff 1
03/03/2025	Contact - Telephone call made

	Made with administrator. Administrator reported staff 5 no longer works for the facility
03/05/2025	Contact - Telephone call made Interview with staff 1
03/11/2025	Exit – Email Report sent to admin/AR

ALLEGATION:

Lack of adequate care for Resident A

INVESTIGATION:

On 1/15/2025, the department received this online complaint.

According to the complaint, on 12/18/2024, Resident A, who required oxygen assistance, was gasping for air for several hours. Staff did not provide oxygen, reporting it was not available and did not contact emergency medical services (EMS) even though they were informed at least four times that Resident A was having difficulty breathing. Resident A passed away on 12/19/2024.

On 1/15/2025, I interviewed Complainant by telephone. Complainant stated that on 12/18/2024, Resident A contacted Relative A by telephone at approximately 11:15am stating she was having trouble breathing. Complainant stated Resident A was encouraged to use her call pendant to summons staff and did so. Complainant stated that after using her call pendent, staff 1 came in the room first. Complainant stated Resident A informed staff 1 she was having a difficult time breathing. Complainant stated Resident A was using a concentrator, as she required continuous oxygen, due to having COPD (chronic obstructive pulmonary disease) so staff 1 checked the oxygen cord to insure it was not tangled. Complainant stated staff 1 then left to get staff 2. Complainant stated that after several minutes, staff 2 came to the room and when Resident A told staff 2 she was having difficulty breathing, staff 2 left to get other staff. Complainant stated Relative A contacted Relatives B and C to inform them of the situation. Complainant stated Resident A had a camera in her room which would record when activated by family. Complainant stated family could communicate through the camera device also. Complainant stated Relative B activated the camera at approximately 11:43am. Complainant stated the camera recorded until approximately 12:01pm, around the time Relatives A and C arrived at the facility. Complainant stated that during the time the camera was recording, several staff were in and out of the room. Complainant stated that when the camera came on, Resident A could be seen gasping for air while staff present, staff 3, 4 and 5, communicate with Resident A and discuss administering Resident A her prescribed morphine. Complainant stated staff 2

returned with Resident A's morphine for staff 4 to administer. Complainant stated staff continued to attempt to take a pulse ox reading (oxygen saturation level in the blood) unsuccessfully on several parts of Resident A's body, even attempting to do so on her toe though Resident A had neuropathy in her toes making a reading impossible there. Complainant stated staff apparently attempted to take a pulse ox reading with several devices and could not get a reading at that time. Complainant stated that during this time, staff 3 bent down toward the oxygen concentrator next to Resident A's bed and that when she came back up, the concentrator was beeping. Complainant stated it was unclear if the concentrator was working correctly. Complainant stated Relative B was speaking to staff through the camera telling staff to get a back up oxygen tank and telling them where the tanks were as they apparently did not know. Complainant stated Resident A had at least one portable tank in her closet and as many as five in a janitors closet down the hall from Resident A's room. Complainant stated this was confirmed when Relative A arrived at the facility and showed staff where the tanks were located. Complainant stated a call was placed to emergency medical services (EMS) at 11:53am, from Resident A's phone. Complainant stated Resident A briefly spoke with EMS, expressing her difficulty breathing, before staff 3 obtained the phone to speak with EMS. Complainant stated that after speaking with EMS, staff 3 can be seen on the video, at approximately 12:01pm, talking with Health Care Solutions (HCS) who staff 3 apparently called to discuss the oxygen concentrator since it had been beeping. Complainant stated that when speaking with HCS, staff 3 can be heard telling HCS the concentrator will go above five and above if needed. Complainant stated the concentrators highest level was five which staff 3 apparently observed during the call. Complainant stated staff 4 checked the concentrator and reported that it was set to level three. Complainant stated Resident A's concentrator was supposed to be at a minimum of four. Complainant stated staff still had not located one of Resident A's back up portable tanks. Complainant stated staff did finally bring in a different concentrator but were unable to get it running for Resident A to use before EMS arrived at approximately 12:10pm. Complainant stated that when EMS arrived, they administered albuterol to Resident A which complainant stated Resident A was allergic to. Complainant stated Resident A is prescribed Levalbuterol and that this medication was available in the med cart at the facility. Complainant stated staff reported that EMS refused to use medication from the facility and that they were going to use what they had which was albuterol. Complainant stated that Resident A passed away on 12/19/2024. Complainant stated that after Resident A passed away, Relative A received a text message reporting that staff 1 and 5 had both observed Resident A at least four times, between the two of them, several hours prior to Resident A's initial call to Relative A, having difficulty breathing. Complainant stated the message indicated staff 1 and 5 informed staff 2, the med tech responsible to Resident A that morning, of Resident A's difficulty with staff 2 apparently not taking any action. Complainant stated the belief that staff did not take adequate action to address Resident A's clear medical needs on the morning of 12/18/2024.

I reviewed video footage, provided by complainant. The total video footage was separated into seven small videos spanning the time described by complainant and appeared consistent with statements provided by complainant.

On 1/16/2025, I interviewed administrator Staci Tripolsky at the facility. Administrator stated she was not aware of any concerns regarding staff response to Resident A during her last morning at the facility. Administrator stated Resident A had been to the hospital recently related to difficulties breathing. Administrator stated Resident A was having dips in her oxygen and that the facility was having difficulty maintaining her oxygen. Administrator stated that if care staff notice a resident having difficulties outside of their normal baseline, care staff would be expected to report these issues to the med tech and/or supervisors on duty. Administrator stated she was not aware of any reports from earlier in the morning, prior to Resident A contacting family, of Resident A having abnormal difficulties breathing.

On 1/16/2025, I interviewed staff 2 at the facility. Staff 2 stated she was assigned to pass medications on the morning of 12/18/2024. Staff 2 stated she first saw Resident A at approximately 8am when she went into her room to pass medications. Staff 2 stated Resident A did not report any abnormal difficulties breathing to her at that time and did not appear to be outside of baseline. Staff 2 stated Resident A was using an oxygen concentrator at that time. Staff 2 stated she could not recall what level the concentrator was set at or what it was supposed to be set at and that this would be defined in the service plan. Staff 2 stated it was not until around approximately 11:15am on 12/18/2024 that she was approached by staff 5 who reported having observed Resident A having difficulty breathing. Staff 2 stated she had not been notified prior to this that Resident A was having any difficulty breathing beyond what was normal for her. Staff 2 stated that after the reporting, she went to Resident A's room to check for kinks in the concentrator hose and to get a pulse ox reading. Staff 2 stated Resident A's concentrator appeared to be working correctly at the time. Staff 2 stated Resident A had a pulse ox reading of 76. Staff 2 stated she stepped out of Resident A's room and used an assigned walkie talkie to call for assistance from management. Staff 2 stated she called for a "stat" (immediate) response. Staff 2 stated that a few minutes later, staff 3 and 4 came to assist. Staff 2 stated staff 6 also came to the room at some point. Staff 2 stated that at some point, Resident A's concentrator started making a loud noise. Staff 2 stated that staff 4 and 6 looked at the concentrator and could not figure out what was causing the noise. Staff 2 stated she was asked by staff 4 to retrieve a backup oxygen tank for Resident A but she did not know where to locate one. Staff 2 stated that staff 3, 4 and 6 all reported they did not know where Resident A had any backup oxygen tanks stating, "there appeared to be some confusion as to where any back up oxygen was stored". Staff 2 stated it was her understanding that the concentrator Resident A was using was not working correctly. Staff 2 stated it was later pointed out that Resident A had back up oxygen tanks in the janitors closet down the hall from her room. Staff 2 stated that when EMS arrived at the facility, she informed them that Resident A was prescribed Levalbuterol and offered to give them the medication for Resident A. Staff 2 stated EMS declined this offer. Staff 2 stated she

had also given EMS Resident A's RESIDENT INFORMATION sheet, as they got off the elevator and before they reached Resident A's room, which staff 2 stated has a list of Resident A's allergies.

On 1/16/2025, I interviewed staff 4 at the facility. Staff 4 stated she was not originally working on Resident A's floor, the third floor, the morning of 12/18/2024. Staff 4 stated she did not hear any call from staff 2 requesting help for Resident A. Staff 4 stated she became aware of the situation after she happen to go to the third floor to chart on another resident. Staff 4 stated it was sometime after 11am at this point Staff 4 stated she saw staff 2 at a medication cart (med cart) and that staff 2 asked her if a pulse ox reading of 76 was too low. Staff 4 stated that because the pulse ox reading was considered a low reading, she went to Resident A's room to check on her. Staff 4 stated that when she entered the room, Resident A was gasping for air and "breathing in a way I had never seen". Staff 4 stated staff 3 had asked if anyone knew where Resident A had any back up oxygen and that staff 3 had called over the walkie talkie asking for oxygen. Staff 4 stated she could not be sure if the concentrator Resident A had been using was working correctly. Staff 4 stated the concentrator was making a loud noise. Staff 4 stated a new oxygen concentrator was eventually brought to the room, but that EMS arrived to transport Resident A before the concentrator could get set up. Staff 4 stated that Relative A was present at this time and escorted staff down the hall to the janitors closet where Resident A had additional oxygen tanks stored. Staff 4 stated that after EMS took Resident A to the hospital, staff 1 and 5 both reported that between the two, they had told staff 2 "at least four times" that morning that Resident A was having difficulty breathing beyond normal.

On 1/16/2025, I interviewed staff 3 at the facility. Staff 3 stated that on the morning of 12/18/2024, she heard staff 2 call over the walkie talkie for her specifically so she went to Resident A's room. Staff 3 stated staff 2 had called over the walkie talkie more than once. Staff 3 stated she was working on a different floor at the time. Staff 3 stated she did not respond immediately to the first call because the way staff 2 made the call did not sound like an immediate issue. Staff 3 stated that when she first arrived in Resident A's room, she said, "we need to have her sent out" and heard a voice say, "no don't do that". Staff 3 stated she could not be sure who said it. Staff 3 stated staff 2 was present in the room at that time and reported Resident A was having difficulty breathing and had a pulse ox reading in the 70's. Staff 3 stated she tried to obtain a pulse ox reading for Resident A with several different devices and several different areas on her body but was unable to get a reading. Staff 3 stated that when she first arrived in Resident A's room, Resident A's concentrator appeared to be working correctly and did not have kinks in the air hose. Staff 3 stated the concentrator was set at 3 and that she believed that was where it was supposed to be set at. Staff 3 stated that at some point, the concentrator was making a noise and flashing red and orange. Staff 3 stated she was concerned the concentrator was not working correctly so she called over the walkie talkie for someone to bring another source of oxygen. Staff 3 stated she and other staff in the room at that time were unsure where Resident A had back up oxygen. Staff 3 stated

this was not the first time Resident A had this issue and that usually they would just give her more oxygen and Resident A would be fine. Staff 3 stated that when EMS arrived in the room, she asked EMS responders to hold off using albuterol for Resident A, due to Resident A being allergic to it, and asked staff 2 to get Resident A's Levalbuterol and that EMS declined the Levalbuterol. Staff 3 stated that after Resident A went to the hospital, staff 1 told her that she had informed staff 2 that morning that Resident A was having increased difficulty breathing and was unsure if staff 2 checked on her for this issue prior to the time she actually took action to try and obtain assistance.

On 1/16/2025, I interviewed staff 6 at the facility. Staff 6 stated that on the morning of 12/18/2024, she became involved after she heard staff 3 calling for back up oxygen over the walkie talkie. Staff 6 stated that when she heard the call, she went to Resident A's room as she thought Resident A was supposed to have a backup oxygen tank in the closet of her room. Staff 6 stated the oxygen was not in the closet and that staff, including herself, did not know where any other tanks were located. Staff 6 stated she was not aware that Resident A had been having difficulties breathing earlier that morning. Staff 6 stated she was aware Resident A had been to the hospital recently, but did not believe it was related to breathing issues. Staff 6 stated staff had been having a difficult time getting a pulse ox reading for Resident A, but that eventually they were able to obtain one. Staff 6 stated EMS was eventually contacted because the pulse ox reading was still low.

On 3/03/2025, I interviewed staff 5 by telephone. Staff 5 stated that on the morning of 12/18/2024, she first saw Resident A at approximately 7:40am as she was assisting Resident A to use the bathroom. Staff 5 stated that after assisting Resident A with toileting, she assisted Resident A back into bed at which time she stated Resident A reported she was having trouble breathing. Staff 5 stated she checked Resident A's concentrator cord which she stated was not tangled and that the checked the concentrator itself which she stated was set at three. Staff 5 stated Resident A's concentrator was usually set at three. Staff 5 stated that after she assisted Resident A into bed, she notified staff 2 that Resident A was reporting having difficulty breathing. Staff 5 stated that approximately 20 minutes after this, sometime after 8am, Resident A used her pull cord to notify staff she needed assistance, so she checked on Resident A. Staff 5 stated Resident A reported again that she was having difficulty with her breathing and appeared concerned about it. Staff 5 stated Resident A reported staff 2 had not yet come to her room to check on her. Staff 5 stated she notified staff 2 again of Resident A's breathing difficulties and concerns. Staff 5 stated she was not sure after that if staff 2 went to check on Resident A at that time. Staff 5 stated staff 1 had also provided care to Resident A that morning and believed Resident A may have reported similar issues to staff 1 as well.

On 3/05/2025, I interviewed staff 1 by telephone. Staff 1 stated that on the morning of 12/18/2024, she went to Resident A's room at least two times after Resident A summoned staff with her call pendent. Staff 1 stated that she could not recall the

times she was in the room, but stated the first time was earlier in the morning. Staff 1 stated Resident A reported having a difficult time breathing. Staff 1 stated she verbally notified staff 2 of Resident A's complaint. Staff 1 stated she did not know if staff 2 went to Resident A's room at that time. Staff 1 stated the second time she could remember going Resident A's room was around 11am at which time she stated Resident A was again having difficulty breathing. Staff 1 stated she reported this to staff 2 and staff 2 went into Resident A's room to attend to her. Staff 1 stated she did not go back to Resident A's room after this.

I reviewed Resident A's *RESIDENT INFORMATION* record, provided by administrator. Under a section of the titled *Allergies*, the record read "Aspirin, Codeine, Benadryl, Demerol, Motrin, Sulfa Antibiotics, Trimethoprim Vancomycin".

I reviewed *HOSPITAL DISCHARGE SUMMARY* documents from *UNIVERSITY OF MICHIGAN HOSPITAL*, for Resident A provided by administrator. According to the documentation, Resident A was admitted on 11/28/2024 for "Sepsis with acute hypoxic respiratory failure (occurs when your lungs cannot release enough oxygen into your blood, … Respiratory failure happens when the capillaries, or tiny blood vessels surrounding your air sacs, cannot properly exchange carbon dioxide and/or oxygen) without septic shock".

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.** **(c) Assure the availability of emergency medical care required by a resident.**

ANALYSIS:	The complaint alleged that on the morning of 12/18/2024, staff did not adequately respond to Resident A's needs, leading to a lack of appropriate medical intervention. The investigation revealed Resident A was a person with a history of COPD who had frequent difficulties breathing and had recently been to the hospital related to respiratory issues. Interviews with staff revealed that, while denied by staff 2, there were several reports on the morning of 12/18/2024, hours before staff began to intervein, that Resident A was having difficulties breathing beyond her normal baseline. Several staff present with Resident A, after staff began to check on her related to her breathing difficulties, reported that at some point, they could not be sure if Resident A's oxygen source was working, and no staff present knew where Resident A's backup oxygen was located. Even after staff began to intervein, it still took approximately 40 minutes for EMS to be contacted even though Resident A was reportedly having increased and noticeable difficulty breathing and staff were unable to locate oxygen for her. Based on the findings, the allegations are supported.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Improper medication administration

INVESTIGATION:

When interviewed, Complainant stated Resident A was prescribed morphine and klonopin. Complainant stated these medications were physician ordered to be given at least one hour a part. It was reported that on the morning of 12/18/2024, Resident A was given these medications together.

When interviewed, administrator stated she was made aware of concerns that on the morning of 12/18/2024, Resident A may have been administered morphine and klonopin too close together. Administrator stated that according to medication administration records, this did not happen. Administrator stated that when staff administer a medication, they have to enter this into the facilities medication administration record (MAR) system and that the time of the administration is stamped in the system and can be reviewed on a generated report.

When interviewed, staff 2 stated she did administer Resident A her Klonopin and morphine on the morning of 12/18/2024. Staff 2 stated she was aware that these medications had to be administered at least an hour apart and that she did not administer them less than an hour apart. Staff 2 stated these instructions were

specified on Resident A's medication administration record as well as on a posted sign in Resident A's room.

I reviewed the *Medication Admin Audit* report for Resident A, provided by administrator. The report indicates Resident A was administered her morning prescribed dose of *MORPHINE SULF* at 8:34am and administered her morning prescribed *CLONAZEPAM* (name brand for Klonopin) at 9:37am.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	The complaint alleged Resident A was prescribed morphine and Klonopin and that they were administered within less than an hour of each other though the requirement was for the medications to be administered at least an hour apart. The findings of the investigation do not support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESITGATION:

Review of Resident A's *RESIDENT INFORMATION* record revealed no albuterol was not listed under the *Allergies* section.

APPLICABLE RULE	
R 325.1942	**Resident records.**
	(3) The resident record shall include at least all of the following: **(f) Health information, as required by MCL 333.20175(1), and other health information needed to meet the resident's service plan.**

ANALYSIS:	While staff reported having informed EMS of Resident A's allergy to albuterol and the availability of Levalbuterol, review of Resident A's resident record document revealed her allergy to albuterol was not listed. Based on the finding, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

03/10/2025

Aaron Clum — Date
Licensing Staff

Approved By:

03/11/2025

Andrea L. Moore, Manager — Date
Long-Term-Care State Licensing Section